OKLAHOMA DEPARTMENT OF HUMAN SERVICES

NOTIFICATION CONCERNING FINDING(S) OF CHILD ABUSE/NEGLECT

PLAINTIFF'S EXHIBIT 14

To: Joe Washington
MUSKOGEE COUNTY REGIONAL
JUVENILE DETENTION
601 W Shawnee Street
Muskogee, Oklahoma 74401-

You are entitled to notification of findings after completion of a child abuse/neglect investigation in your facility.

Date of referral: 12/15/2016

Referral number: 1806285

Overall finding following an investigation by the Office of Client Advocacy:

Substantiated

Investigation Summary:

This case named one alleged victim, Billy Woods, a 16-year-old in the custody of the Arkansas Office of Juvenile Affairs, and four accused staff, Shift Supervisor Jerrod Lang, Detention Worker (DW) Marietta "Jackie" Winkle, DW Brandon Miller, and DW Angela Miller. Woods was found unconscious and unresponsive in his room at approximately 8:36 pm on 12-15-16 by Lang. Lang called for other residents to be locked down. Lang, Winkle, and B. Miller were in Woods's room at various times following his discovery. None of the staff attempted to remove the sheet from his neck or to perform CPR on him. Lang, Winkle, and B. Miller had been in the West Wing, where Woods was housed in Room One, at various times during the approximately two hours and two minutes that he went unchecked after entering his room at approximately 6:34 pm. None of the staff opened his door or the flap covering the window in his door in order to perform required 15-minute checks on Woods. A. Miller was stationed in the control center during the time in question and should have been monitoring Woods via the intercom. After placing residents on lockdown, staff checked only one resident approximately 26 minutes later. The remaining residents on West Wing were not checked for approximately one hour and 45 minutes. None of the staff followed policies and procedures for 15-minute checks of Woods or other residents. Woods's Daily Notes sheet had initials "JL" and "BM" documented for 15 minute checks being completed from 3:00pm to 10:45pm. There is a line drawn through the initials from 8:45pm to 10:45pm as Woods was found deceased during this time period. Winkle reported staff are required to document 15 minute checks of residents. She stated if a resident was in their room, staff could check through the window in the door. Winkle reported Lang told staff the residents needed to be placed on lock down and after the residents were placed in their cells, Lang informed staff that Woods was dead. Winkle reported she went to "go see for myself." Winkle stated she did not check if Woods was breathing or if he had a pulse. When asked if 15-minute checks were conducted on residents after they were placed on lockdown following the discovery of Woods's body, Winkle said, "[I] don't think so." Lang reported during Woods's intake, Woods disclosed he had attempted suicide "a lot." Lang stated Woods told him the last attempt was about a month prior by hanging. Lang stated he was going to speak with Washington about what Woods disclosed, but he forgot to. Lang stated the Daily Notes were kept in the control room and stated that is where the 15 minute checks were documented. When asked about the line being drawn through the times after Woods was found deceased, Lang stated "[I] jumped the gun on my paperwork." Lang also admitted he added Miller's initials to the Daily Notes as completing 15 minute checks. Lang said when he went to take a snack to Woods, he opened the door to Woods's cell, and said, "He [Woods] was deceased." Lang said he called Woods's name, and then he shut the door when Woods did not respond

or move. When asked how he knew Woods was "deceased," Lang said it was "obvious" because Woods was "purple" and "pale-ish." Lang said he went to tell the other staff to place kids on lockdown. Lang said he told staff he "just found Billly in room, dead." Lang said he told staff to call Washington and 911. During his interview B. Miller reported he only saw resident Woods at shower time, which was somewhere between 6:40 pm and 7:00 pm. B. Miller said after Woods finished showering, Woods put his clothes in a hamper and requested to go back to his room. Miller said Lang gave approval for Woods to return to his room. Miller said that was the last time he saw Woods. B. Miller reported Lang told staff after the residents were locked down that Woods hanged himself. A. Miller told him and Lang to administer CPR. B. Miller said he and Lang went to Woods's cell and Lang advised him to not complete CPR since Woods was already deceased. When asked if he completed required 15-minute checks, B. Miller said he had not. When asked why his initials were on the notes sheet indicating he had completed the checks, B. Miller said Lang wrote his initials on the sheet. A. Miller reported in her interview she was assigned to the control room the night Woods committed suicide. A. Miller reported Lang placed the residents on lockdown and then told all staff, "that boy hung himself." A. Miller reported she asked if CPR was tried and when told no, she told Lang and B. Miller to go do CPR. A. Miller reported both supervisors, Lang and Winkle, did not know the protocol in this situation. A. Miller reported she told winkle to call Washington. A. Miller reported they had to call Washington back and ask if 911 needed to be called. There was a 20 minute delay of 911 being called after Woods was found in his cell. OCA's investigation has determined, based on some credible evidence, the allegation of NEGLECT LACK OF SUPERVISION by LANG, WINKLE, B. MILLER, and A. MILLER is SUBSTANTIATED. It was further discovered during the course of the investigation that Lang made fun of Woods's name and the way he walked. Reportedly, that contributed to Woods not wanting to be out of his room. Three residents confirmed Lang made fun of Woods. One resident also reported he told Lang he should probably check on Woods because "he could be in there killing himself." This resident stated staff did not go check Woods. The allegation of ABUSE-MENTAL INJURY by LANG is SUBSTANTIATED. CARETAKER MISCONDUCT is also CONFIRMED as Lang, Winkle, B. Miller and A. Miller did not follow their own procedures for Emergency Procedures. Nobody administered CPR and 911 was not called prior to notifying the Administrator since it was a life or death situation.

Area(s) of Concern:

Please see the list of AOCs in the Collateral Interview section.

Final Approval Date: 04/18/2017

SHANNON IWANSKI AMY BATEMAN

Worker Supervisor

Kathryn Boyle Brewer

Advocate General

OKDHS is required to make a finding in accordance with the definitions contained in Section 1-9-112.1 of Title 10A of Oklahoma Statutes.

"Substantiated" means OCA has determined, after an investigation of a report of child abuse or neglect of a child and based upon some credible evidence, that child abuse or neglect occurred;

"Unsubstantiated" means OCA has determined, after an investigation of a report of child abuse or neglect of a child, that insufficient evidence exists to fully determine whether child abuse or neglect occurred; or

"Ruled Out" means OCA has determined, after an investigation of a report of child abuse or neglect of a child, that no child abuse or neglect occurred.